STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150161	A. BUILDING _____ B. WING _____	01/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA UNIVERSITY HEALTH NORTH HOSPITAL	**11700 N MERIDIAN ST CARMEL, IN 46032**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of 1 (one) State hospital complaint. Complaint: #IN00096068 Unsubstantiated; lack of sufficient evidence. Facility: #004171 Date: 1-19-2012 Surveyor: Karilyn M. Tretter, RN Public Health Nurse Surveyor Indiana University Health North Hospital is in compliance with 410 IAC 15-1.5-6, Nursing services and 410 IAC 15-1.6.8, Surgical services, Indiana State Hospital Licensure Rules. QA: claughlin 02/17/12	S 000		